2001 Open Enrollment for 2002

Regular Retiree Benefits Participant with Medical and Vision

This guide explains your benefits and changes to them in 2002, plus the changes you can make to your coverage during this open enrollment. The guide includes a Resource Directory listing whom to contact if you have any questions (page 8), plus the forms you need to make changes (pages 9-12).

During open enrollment you may:

- Change medical plans
- Drop vision and continue medical coverage only
- Add new eligible family members for coverage
- Drop currently covered family members from coverage.

Please review the guide and if you decide to make changes, return the forms **by Friday, November 30** to:

Associated Administrators, Inc.
PO Box 3988
Portland OR 97208-3988

If you decide to keep the same coverage in 2002, do nothing -- simply keep all materials for reference.

This guide is not a complete description of each plan. More details about each benefit are in your plan booklets, available at www.metrokc.gov/ ohrm/ benefits or in alternate formats from Benefits & Well-Being. Although we've made every effort to ensure this guide is accurate, provisions of the official plan documents and contracts will govern in the case of any discrepancy. As explained in the plan booklets, the benefit program is subject to review and may be modified or terminated at any time for any reason. This guide does not create a contract of employment between King County and any former employee.

King County Office of Human Resources Management
BENEFITS & WELL-BEING

What's Changing in 2002

In 2002, vision plan benefits remain the same, but costs increase for all benefits and there are some changes to the medical plans:

- For all medical plans the chemical dependency treatment maximum increases from $10,326 to $10,680 in any consecutive 24 months.
- For the PacifiCare Choice and HMO plans there is a $50 copay for smoking cessation.
- For the VM/GH Alliant plan the copay for an emergency room visit changes from $50 (waived if admitted) to $75 for a network facility (waived if admitted); $125 for a non-network facility.
- KingCare/Aetna is currently renegotiating its network provider agreement with Swedish Medical Delivery Systems (Swedish Hospital-First Hill, Swedish Hospital-Ballard, Providence Hospital and related clinics) and, unfortunately, it won't be known whether Swedish will be an Aetna network provider beyond Jan. 31, 2002 until after open enrollment. (PacifiCare has just signed a new agreement with Swedish. Assuming Swedish does not exercise its option to unilaterally terminate the agreement, it should be a network provider through 2002.)

The medical plan you pick during open enrollment is the plan you have through 2002 even if the plan's network providers change. Keep in mind, though, if Swedish does not reach a new agreement with KingCare/Aetna or terminates its agreement with PacifiCare, and you're in the KingCare/Aetna Basic, KingCare/Aetna Preferred or PacifiCare Choice medical plan, you may still receive services from Swedish providers at non-network levels (see medical plan summary, pages 3-5).

Cost

Monthly rates for COBRA and retiree rates are based on what King County pays to provide the same coverage for active employees. The following table lists 2001 and 2002 rates. The rate for dependent children applies whether you cover one child or several, as long as you or your spouse also elects self-paid coverage. Add across each row for the family members you cover, then add the row totals for your monthly cost.

Benefit Plan		You	Spouse/DP*	Dependent Child(ren)	Your Cost
KingCare (Aetna/Ethix)	*2001*	$ 236.99	$ 236.99	$ 189.59	
Basic Medical	*2002*	$ 272.83	$ 272.83	$ 218.26	
KingCare (Aetna/Ethix)	*2001*	$ 278.81	$ 278.81	$ 223.04	
Preferred Medical	*2002*	$ 320.97	$ 320.97	$ 256.77	
PacifiCare	*2001*	$ 259.12	$ 259.10	$ 207.32	
Choice Medical	*2002*	$ 287.78	$ 287.75	$ 230.24	
PacifiCare	*2001*	$ 224.42	$ 224.41	$ 179.53	
HMO Medical	*2002*	$ 249.24	$ 249.24	$ 199.39	
VM/GH	*2001*	$ 243.42	$ 243.43	$ 194.76	
Alliant Medical**	*2002*	$ 292.18	$ 292.19	$ 233.76	
Vision Service Plan	*2001*	$ 8.23	$ 8.23	$ 6.58	
	2002	$ 8.78	$ 8.78	$ 7.03	
				Monthly Total	

* DP = Domestic Partner

** If you were a part-time Local 587 employee self-paying for medical coverage under Plan 1 or 3 when you left employment, your monthly rates for Alliant in 2002 are $253.38 for you, $253.43 for spouse/DP and $202.70 for dependent child(ren). The lower rates are due to the lower experience rating for active employees in Plan 1 and 3.

■ Medical

Do you want to change medical coverage? You may choose from five plan options. The option you select is the option your family members receive.

Generally, the plans on the left in the following tables offer a greater selection of covered providers but lower benefit levels. Plans on the right offer higher benefit levels but less selection of covered providers.

Plan Feature	KingCare (Aetna/Ethix) Basic Plan	KingCare (Aetna/Ethix) Preferred Plan	PacifiCare Choice Plan	PacifiCare HMO	VM/GH Alliant Plan
Provider choice	Your choice of providers; you receive higher coverage when you see network providers	Your choice of providers; you receive higher coverage when you see network providers	Your choice of providers; you receive higher coverage when your PCP* coordinates or provides your care	Your PCP* coordinates or provides all of your care	Your choice of Virginia Mason or Group Health providers; your PCP* coordinates or provides all care within their network
Annual deductible	$250/person; $750/family	$50/person; $150/family	None	None	None
Annual out-of-pocket maximum/ person	$800 network; $1,600 non-network	$400 network; $1,200 non-network	$0 network; $1,600 non-network	$0 network; no coverage non-network	$1,000 network; no coverage non-network
Lifetime maximum	$2,000,000	$2,000,000	$2,000,000	No limit	No limit
Alternative care	80% network; 60% non-network	90% network; 70% non-network	100% after $10 copay/visit PCP-directed*; 100%, after $20 copay/visit self-directed	100% after $10 copay/visit PCP-directed*; 100%, after $20 copay/visit self-directed	100% after $10 copay/visit for specific services; PCP referral required
Chemical dependency treatment	80% network; 60% non-network; $10,680 max/24 mos	100% network; 70% non-network; $10,680 max/24 mos	100% Behavioral Health-directed; 60% self-directed; $10,680 max/24 mos	100% (Behavioral Health must refer); $10,680 max/24 mos	100% for inpatient; 100% after $10 copay/visit for outpatient; $10,680 max/24 mos
Chiropractic care (as with most other benefits, must be medically necessary)	80% network; 60% non-network; up to 33 visits/yr; limited to diagnosis and treatment of musculoskeletal disorders	90% network; 70% non-network; up to 33 visits/yr; limited to diagnosis and treatment of musculoskeletal disorders	100% after $10 copay/visit PCP-referred; 100% after $20 copay/visit self-directed network or non-network; up to 33 self-directed visits/yr	100% after $10 copay/visit; must use network provider	100% after $10 copay/visit; must use network provider
Circum-cision	80% network; 60% non-network	90% network; 70% non-network	100% PCP-directed; 60% self-directed	100%	100%
Durable medical and diabetic equipment (prior approval required)	80%	80%	80% PCP-directed; 50% self-directed	100%	80%

* PCP means your primary care physician.

Plan Feature	KingCare (Aetna/Ethix) Basic Plan	KingCare (Aetna/Ethix) Preferred Plan	PacifiCare Choice Plan	PacifiCare HMO	VM/GH Alliant Plan
Emergency care (in an emergency room)	80% after $50 copay/visit (waived if admitted)	90% after $50 copay/visit (waived if admitted)	100% after $50 copay/visit (waived if admitted)	100% after $50 copay/visit (waived if admitted)	100% after $75 copay/visit at a network facility (waived if admitted); $125 copay/visit at a non-network facility
Emergency care while traveling	Emergency care is covered at network levels whether you see a network or non-network provider	Emergency care is covered at network levels whether you see a network or non-network provider	Emergency care is covered at network levels whether you see a network or non-network provider	Emergency care is covered at network levels whether you see a network or non-network provider	Emergency care is covered at network levels whether you see a network or non-network provider
Hospital care	80% network; 60% non-network	90% network; 70% non-network	100% PCP-directed; 60% self-directed	100%	100%
Infertility	80% network; 60% non-network; limited to specific services and $25,000 lifetime max	90% network; 70% non-network; limited to specific services and $25,000 lifetime max	Not covered	Not covered	Not covered
Lab, x-rays and other diagnostic testing	80% network; 60% non-network	90% network; 70% non-network	100%	100%	100%
Massage therapy (as with most other benefits, must be medically necessary)	80% network; 60% non-network; physician prescribed only (after 20 visits Aetna reviews)	90% network; 70% non-network; physician prescribed only (after 20 visits Aetna reviews)	100% after $10 copay/visit network; 100% after $20 copay/visit non-network; PCP referral required	100% after $10 copay/visit; PCP referral required; must use network provider	100% after $10 copay/visit; PCP referral required; must use network provider
Mental health care — inpatient	80% network; 60% non-network; up to 30 days/yr	90% network; 70% non-network; up to 30 days/yr	100% (Behavioral Health must refer); 60% self-directed; up to 30 days/yr	100% up to 30 days/yr (Behavioral Health must refer)	80% up to 12 days/yr
Mental health care — outpatient	50% up to 52 visits/yr (when deemed appropriate, unused visits may be traded for unused inpatient days)	50% up to 52 visits/yr (when deemed appropriate, unused visits may be traded for unused inpatient days)	50% up to 52 visits/yr (Behavioral Health must refer); 50% up to 9 visits/yr self-directed	100% after $10 copay/visit, up to 30 visits/yr (Behavioral Health must refer)	100% after $20 copay/individual, family or couple for each visit and $10 copay/group session (up to 20 visits/yr)
Out-of-area coverage for your children away at school	Same benefits you receive at home, through Aetna's national provider network	Same benefits you receive at home, through Aetna's national provider network	Outside PacifiCare's service area benefits are slightly different; for example, most services are covered at 80%	Outside PacifiCare's service area benefits are slightly different; for example, most services are covered at 80%	In E and SW WA and N OR care is available through associated HMOs; in all other areas only emergency care is covered

Plan Feature	KingCare (Aetna/Ethix) Basic Plan	KingCare (Aetna/Ethix) Preferred Plan	PacifiCare Choice Plan	PacifiCare HMO	VM/GH Alliant Plan
Physician and other medical and surgical services**	80% network; 60% non-network	90% network; 70% non-network	100% after $10 copay/visit PCP-directed; 100% after $20 copay/visit self-directed	100% after $10 copay/visit	100% after $10 copay/visit
Prescription drugs — network (must use participating pharmacies)	100% after $5 copay generic/30-day supply; $10 copay brand name/30-day supply	100% after $5 copay generic/30-day supply; $10 copay brand name/30-day supply	100% after $5 copay generic/30-day supply; $10 copay brand name/30-day supply	100% after $5 copay generic/30-day supply; $10 copay brand name/30-day supply	100% after $5 copay generic/30-day supply; $10 copay brand name/30-day supply
Prescription drugs — mail order	100% after $10 copay/100-day supply	100% after $10 copay/100-day supply	100% after $10 copay/90-day supply	100% after $10 copay/90-day supply	100% after $5 copay generic or $10 copay brand name; 30-day supply
Preventive care (such as routine exams and immuniza-tions)	100% network; 60% non-network	100% network; 70% non-network	100% after $10 copay/visit PCP-directed; not covered self-directed	100% after $10 copay/visit	100%
Skilled nursing facility	80% network; 60% non-network	90% network; 70% non-network	100% PCP-directed; 60% self-directed; up to 100 days/yr	100% up to 100 days/yr	100% (when pre-authorized)
Smoking cessation -- sessions	80% network; 60% non-network; $500 lifetime max	90% network; 70% non-network; $500 lifetime max	100% after $50 copay/network program	100% after $50 copay/network program	100% network provider; 1 program/yr max
Smoking cessation -- nicotine replacement	If prescribed and full course of treatment completed	If prescribed and full course of treatment completed	100% after $20 copay for one 4-week supply if prescribed by PCP	100% after $20 copay for one 4-week supply if prescribed by PCP	100% or $5 copay/30-day supply (whichever is less) for network program

** Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from mastectomy (including lymphedema). Call the medical plan for more information.

■ Vision

Do you want to keep or drop vision coverage?

Vision coverage is provided through Vision Service Plan (VSP).

Vision Service Plan		
Covered Expenses	**If you see a VSP provider, you pay a $10 copay and the plan pays …**	**If you see a non-VSP provider, you pay the bill in full and the plan reimburses you the following amounts minus the $10 copay …**
Exams (once every 12 months)	100%	Up to $40
Lenses (1 pair every 12 months)		
• Single vision	100%	Up to $40
• Bifocal	100%	Up to $60
• Trifocal	100%	Up to $80
• Lenticular	100%	Up to $125
• Progressive	100%	Not covered
• Tints	100%	Up to $5
• Coatings	100%	Not covered
Frames (once every 24 months)	100% (selected frames)	Up to $45
Contacts (1 pair every 12 months in place of eyeglass lenses and frames)		
• Elective	100%, up to $105	Up to $105
• Medically necessary	100%	Up to $210

■ Adding and Deleting Family Members

Do you want to keep the same eligible family members covered under your benefit plans? Do you want to add or drop family members?

The following family members are eligible under your coverage if you enroll them:

- Your spouse/domestic partner (copy of marriage certificate or an Affidavit of Marriage/Domestic Partnership required if not previously submitted; page 11)
- Unmarried children of you or your spouse/domestic partner who are:
  - Under age 23 and chiefly dependent on you for support and maintenance (generally, that means you claim them on your federal tax return). A child may be your natural child, adopted child, stepchild, legally designated ward, child placed with you as legal guardian, child legally placed with you for adoption, or a child for whom you assume total or partial legal obligation for support in anticipation of adoption.
  - Named in a Qualified Medical Child Support Order as defined under federal law and authorized by the plan.

To add family members not previously covered, list them on your open enrollment form and provide all information indicated. Include additional documentation as required (Affidavit of Marriage/Domestic Partnership, QMCSO, etc.).

To delete family members from coverage, complete the delete sections on the back of your open enrollment form and provide all information indicated for each deleted family member. This ensures COBRA information is sent to your deleted family members, as required by law. If you delete a spouse/domestic partner from coverage, complete a Termination of Marriage/Domestic Partnership Statement (page 12).

■ Resource Directory

Questions About …	Contact ...
General Benefits	**Benefits & Well-Being** Yesler Building YES-HR-0500 400 Yesler Way, Seattle WA 98104-2683 Phone 206.684.1556* ▪ 1.800.325.6165 x41556* ▪ Fax 206.684.1925 kc.benefits@metrokc.gov ▪ www.metrokc.gov/ohrm/benefits
COBRA and Retiree Benefits Administration • Completing forms • Premium payments	**Associated Administrators Incorporated** PO Box 3988, Portland OR 97208-3988 Phone 1.800.320.2915* ▪ Fax 503.727.7444 aaicobra@aai-tpa.com
Medical • Providers (doctors, hospitals, pharmacies, mail order prescriptions, etc.) • Filing claims • Other plan details (covered expenses, limitations, exclusions, preauthorization)	**KingCare** PO Box 91023, Seattle WA 98111-9123 Phone 1.800.654.3250* x77020 ▪ 206.701.1100* kingcare@aetna.com ▪ www.kingcare.com **Express Scripts** mail order Rx for KingCare PO Box 52123, Phoenix AZ 85027-2123 Phone 1.888.201.5853* ▪ 1.800.296.2956* (refills) www.express-scripts.com **PacifiCare** PO Box 3005, Hillsboro OR 97123 Phone 1.800.932.3004* www.pacificare.com **Prescription Solutions** mail order Rx for PacifiCare PO Box 9040, Carlsbad CA 92018-9040 Phone 1.800.562.6223* www.pacificare.com **Virginia Mason/Group Health Alliant** PO Box 1207, Seattle WA 98111-1207 Phone 1.800.442.4038* info@ghc.org ▪ www.ghc.org/web/health_plans/alliance/allisel.jhtml
Vision • Providers • Filing claims • Other plan details	**Vision Service Plan** PO Box 997100, Sacramento CA 95899-7100 Phone 1.800.877.7195* www.vsp.com

* TTY 1.800.833.6388 (Washington Relay Service)

King County Regular Retiree Benefits Open Enrollment Form
Medical and Vision

If you wish to change coverage, please return forms **by Friday, November 30**
to Associated Administrators Inc., PO Box 3988, Portland OR 97208-3988.
No changes? Do nothing -- simply keep all materials for reference.

■ Plan Participant

First Name _____ MI _____ Last Name _____ Birth Date _____

Social Security Number _____ (Area Code _____) Phone _____

Billing Address _____
Street Apt No City State ZIP

Home Address _____
Street Apt No City State ZIP

■ Covered Family Members

List eligible family members for coverage. Check the box if they're new and attach Affidavit of Marriage/DPship if applicable. Complete back of form if you delete any family members previously covered and attach Termination of Marriage/DPship Statement if applicable.

New	Name	Relationship	Social Security Number	Birth Date	Gender
☐					
☐					
☐					
☐					
☐					
☐					

■ Coverage Options

Check one: ☐ Continue medical and vision ☐ Drop vision -- continue medical only ☐ Drop all coverage

■ Medical Plan

Check one if you continue medical coverage: ☐ KingCare (Ethix/Aetna) Basic ☐ KingCare (Ethix/Aetna) Preferred ☐ PacifiCare Choice ☐ PacifiCare HMO ☐ VM/GH Alliant

■ Authorization

This form supersedes all other forms. I have read and understand it and open enrollment materials describing my options. The information I provided is true, correct and complete. I hereby certify I remain eligible for retiree benefits coverage -- I have not become covered under another group plan. I authorize the insurance carriers to coordinate benefits and process claims for my family and me. I understand the elections I made are binding and cannot be revoked or modified except as explained in the materials provided and until I submit a new form.

Signature _____ **Date Signed** _____

■ **Delete** ☐ Spouse ☐ Natural child ☐ Adopted child ☐ Child placed under guardianship
☐ Domestic partner ☐ DP's child ☐ Foster child ☐ Disabled adult child

Gender ☐ Male ☐ Female

Qualifying Event ☐ Death ☐ Child turned 23
☐ Divorce/dissolution of domestic partnership -- attach statement ☐ Child no longer dependent
☐ End of qualified medical child support order -- attach copy ☐ I opt not to pay for coverage

Event Date ____________________

Address required for COBRA notification if deleted person living.

Name ____

Soc Sec No ____________________ Birth Date ____________________

Street ____ Apt No __________

City ____________________ State ________ ZIP ______________

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☐ Domestic partner ☐ DP's child ☐ Foster child ☐ Disabled adult child

Gender ☐ Male ☐ Female

Qualifying Event ☐ Death ☐ Child turned 23
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Gender ☐ Male ☐ Female

Qualifying Event ☐ Death ☐ Child turned 23
☐ Divorce/dissolution of domestic partnership -- attach statement ☐ Child no longer dependent
☐ End of qualified medical child support order -- attach copy ☐ I opt not to pay for coverage

Event Date ____________________

Address required for COBRA notification if deleted person living.

Name ____

Soc Sec No ____________________ Birth Date ____________________

Street ____ Apt No __________

City ____________________ State ________ ZIP ______________

Affidavit of Marriage/Domestic Partnership

Submit this form with your open enrollment form to document a new marriage or domestic partnership.

■ **Check all boxes that apply**

☐ Add my spouse or domestic partner (DP) for benefit coverage.

☐ This form documents my marriage or domestic partnership, but do not add my spouse or DP for benefit coverage at this time.

■ **Check one of the following boxes and provide date**

☐ I (employee) certify my spouse (named below) and I legally married (date) _____.

☐ I (employee) certify my DP (named below) and I began our domestic partnership (date) _____ and we:

- Share the same regular and permanent residence
- Have a close personal relationship
- Are jointly responsible for *basic living expenses**
- Are not married to anyone
- Are both 18 years of age or older
- Are not related by blood closer than would bar marriage in the State of Washington
- Were mentally competent to consent to contract when our domestic partnership began, and
- Are each other's sole domestic partners and are responsible for each other's common welfare.

* *Basic living expenses means the cost of basic food, shelter and any other expenses of a DP paid at least in part by a program or benefit for which the partner qualified because of the DPship. The individuals need not contribute equally or jointly to the cost of these expenses as long as they both agree they are responsible for the cost.*

■ **Authorization**

I understand this affidavit will no longer be effective if my spouse/DP dies or if there is a change of circumstances attested to in this affidavit.

I agree to notify AAI if there is any change of circumstances attested to in this affidavit within 60 days of such change by filing a Statement of Termination of Marriage/Domestic Partnership.

We understand this information will be held confidential and subject to disclosure only upon express written authorization or if otherwise required by law.

We understand this declaration of responsibility for our common welfare may have legal implications under Washington State law.

We understand a civil action may be brought against us for any losses, including reasonable attorney fees, because of a false statement contained in this Affidavit of Marriage/Domestic Partnership.

We certify under penalty of perjury, under the laws of the State of Washington, the foregoing is true and correct.

Participant Signature_____ **Date Signed** _____

Soc Sec No _____

Spouse/DP Signature _____ **Date Signed** _____

Spouse/DP Printed Name _____

Termination of Marriage/Domestic Partnership Statement

Submit this form with your open enrollment form to document a divorce or end of a domestic partnership.

■ **Check one of the following boxes**

☐ The termination is due to the dissolution of our marriage Date: _____

☐ The termination is due to the termination of our domestic partnership Date: _____

☐ The termination is due to the death of my spouse/domestic partner Date: _____

■ **COBRA notification address**

Provide the address of the deleted spouse/domestic partner (if living) so COBRA information can be mailed as required by law.

Spouse/DP Printed Name _____

Spouse/DP Soc Sec No _____

Address _____

_____

■ **Authorization**

I (participant) affirm the affidavit of marriage/domestic partnership attested to and signed by me with my former spouse/domestic partner is terminated as of the date indicated above. I understand I must submit this statement of termination to AAI and mail a signed copy to my surviving former spouse/domestic partner within 60 days of the termination or my former spouse/domestic partner will not be given COBRA election rights. I certify under penalty of perjury, under the laws of the State of Washington, the foregoing is true and correct.

Participant Signature _____ **Date Signed** _____

Soc Sec No _____